

		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0027557</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>ManorCare at Oak Lawn-Kostner</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>06/01/02</u> to <u>05/31/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																									
Address: <u>9401 S. Kostner Ave.</u> <u>Oak Lawn</u> <u>60453</u> <div style="text-align: center;">Number City Zip Code</div>		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
County: <u>Cook</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____																									
Telephone Number: <u>(708) 423-7882</u> Fax # <u>(708) 423-7947</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()																									
IDPA ID Number: <u>520886946018</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																									
Date of Initial License for Current Owners: <u>1977</u>																											
Type of Ownership: <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>		<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County		<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																									
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																									
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																									
	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																									
	<input type="checkbox"/> "Sub-S" Corp.																										
	<input type="checkbox"/> Limited Liability Co.																										
	<input type="checkbox"/> Trust																										
	<input type="checkbox"/> Other _____																										
IRS Exemption Code _____																											
In the event there are further questions about this report, please contact: Name: <u>Gary Geise</u> Telephone Number: <u>(419)252-5731</u>																											

STATE OF ILLINOIS

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Facility Name & ID Number ManorCare at Oak Lawn-Kostner# 0027557 Report Period Beginning: 06/01/02 Ending: 05/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>157</u>	Skilled (SNF)	<u>157</u>	<u>57,305</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>157</u>	TOTALS	<u>157</u>	<u>57,305</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>13,668</u>	<u>8,787</u>	<u>24,705</u>	<u>47,160</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>13,668</u>	<u>8,787</u>	<u>24,705</u>	<u>47,160</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 82.30%

D. How many bed-hold days during this year were paid by Public Aid?

78 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)N/AF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 1977

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 11/01/81 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 148 and days of care provided 20,737Medicare Intermediary CareFirst of Maryland, Inc.

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☐ NO ☒Tax Year: 12/31/03 Fiscal Year: 05/31/03

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number ManorCare at Oak Lawn-Kostner # 0027557 Report Period Beginning: 06/01/02 Ending: 05/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	265,424	25,783	2,595	293,802	2,819	296,621		296,621			1
2	Food Purchase		178,561		178,561		178,561	(679)	177,882			2
3	Housekeeping	163,132	20,800	403	184,335		184,335		184,335			3
4	Laundry	41,493	23,810		65,303		65,303		65,303			4
5	Heat and Other Utilities			124,861	124,861	11,485	136,346		136,346			5
6	Maintenance	61,043	10,059	55,618	126,720		126,720		126,720			6
7	Other (specify):* Medical Waste			1,196	1,196		1,196		1,196			7
8	TOTAL General Services	531,092	259,013	184,673	974,778	14,304	989,082	(679)	988,403			8
	B. Health Care and Programs											
9	Medical Director			20,500	20,500		20,500		20,500			9
10	Nursing and Medical Records	2,370,293	261,921	25,243	2,657,457	48,905	2,706,362		2,706,362			10
10a	Therapy	709,814	6,168	58,849	774,831		774,831		774,831			10a
11	Activities	78,108	3,661	2,354	84,123		84,123		84,123			11
12	Social Services	58,260		182	58,442		58,442		58,442			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,216,475	271,750	107,128	3,595,353	48,905	3,644,258		3,644,258			16
	C. General Administration											
17	Administrative	112,933		498,801	611,734	(225,394)	386,340		386,340			17
18	Directors Fees											18
19	Professional Services			35,209	35,209	(1,453)	33,756	(33,756)				19
20	Dues, Fees, Subscriptions & Promotions			52,523	52,523		52,523	(22,123)	30,400			20
21	Clerical & General Office Expenses	250,921	49,344	216,286	516,551	1,453	518,004	(166,845)	351,159			21
22	Employee Benefits & Payroll Taxes			836,202	836,202	87,972	924,174		924,174			22
23	Inservice Training & Education			1,585	1,585		1,585		1,585			23
24	Travel and Seminar			1,463	1,463		1,463		1,463			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			177,902	177,902		177,902		177,902			26
27	Other (specify):* Personal Purchases			79	79		79	(79)				27
28	TOTAL General Administration	363,854	49,344	1,820,050	2,233,248	(137,422)	2,095,826	(222,803)	1,873,023			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,111,421	580,107	2,111,851	6,803,379	(74,213)	6,729,166	(223,482)	6,505,684			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

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Facility Name & ID Number

ManorCare at Oak Lawn-Kostner

#0027557

Report Period Beginning:

06/01/02

Ending:

05/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			324,677	324,677	55,624	380,301		380,301			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(512)	(512)	18,589	18,077		18,077			32
33	Real Estate Taxes			441,138	441,138		441,138		441,138			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			49,506	49,506		49,506		49,506			35
36	Other (specify):*											36
37	TOTAL Ownership			814,809	814,809	74,213	889,022		889,022			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			45	45		45		45			38
39	Ancillary Service Centers		455,219		455,219		455,219		455,219			39
40	Barber and Beauty Shops			7,633	7,633		7,633		7,633			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			85,958	85,958		85,958		85,958			42
43	Other (specify):* IV, X-ray, Laboratory		128,453	56,203	184,656		184,656		184,656			43
44	TOTAL Special Cost Centers		583,672	149,839	733,511		733,511		733,511			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,111,421	1,163,779	3,076,499	8,351,699		8,351,699	(223,482)	8,128,217			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number ManorCare at Oak Lawn-Kostner

0027557

Report Period Beginning: 06/01/02

Ending: 05/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer-	OHF USE	
		ence	ONLY	
1	Day Care	\$	10	1
2	Other Care for Outpatients			2
3	Governmental Sponsored Special Programs			3
4	Non-Patient Meals	(679)	2	4
5	Telephone, TV & Radio in Resident Rooms	(6,014)	21	5
6	Rented Facility Space			6
7	Sale of Supplies to Non-Patients			7
8	Laundry for Non-Patients			8
9	Non-Straightline Depreciation		30	9
10	Interest and Other Investment Income		32	10
11	Discounts, Allowances, Rebates & Refunds	(12)	21	11
12	Non-Working Officer's or Owner's Salary			12
13	Sales Tax	(333)	21	13
14	Non-Care Related Interest			14
15	Non-Care Related Owner's Transactions			15
16	Personal Expenses (Including Transportation)	(79)	27	16
17	Non-Care Related Fees			17
18	Fines and Penalties	(2,446)	21	18
19	Entertainment			19
20	Contributions		21	20
21	Owner or Key-Man Insurance			21
22	Special Legal Fees & Legal Retainers	(33,756)	19	22
23	Malpractice Insurance for Individuals			23
24	Bad Debt	(155,074)	21	24
25	Fund Raising, Advertising and Promotional	(22,123)	20	25
26	Income Taxes and Illinois Personal Property Replacement Tax			26
27	Nurse Aide Training for Non-Employees			27
28	Yellow Page Advertising			28
29	Other-Attach Schedule Vending & Misc. Income	(2,966)	21	29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (223,482)	\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$	31
32	Donated Goods-Attach Schedule*		32
33	Amortization of Organization & Pre-Operating Expense		33
34	Adjustments for Related Organization Costs (Schedule VII)		34
35	Other- Attach Schedule		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$	36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (223,482)	37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38	Medically Necessary Transport.	X	\$		38
39					39
40	Gift and Coffee Shops	X			40
41	Barber and Beauty Shops	X			41
42	Laboratory and Radiology	X			42
43	Prescription Drugs	X			43
44	Exceptional Care Program	X			44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)		\$		47

ManorCare at Oak Lawn-Kostner

ID# 0027557

Report Period Beginning: 06/01/02

Ending: 05/31/03

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Vending Income	\$ (1,253)	21	1
2	Misc. Income	(1,713)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(2,966)		49

Summary A

05/31/03

05/31/03

[illegible]

Summary B

Facility Name & ID Number	ManorCare at Oak Lawn-Kostner	#	0027557	Report Period Beginning:	06/01/02	Ending:	05/31/03
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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Facility Name & ID Number ManorCare at Oak Lawn-Kostner# 0027557

Report Period Beginning:

06/01/02

Ending:

05/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Manor Care, Inc.	100	Health Care & Retirement Corporation of America (See H.O. Cost Report)	Toledo, OH			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3	Cost Per General Ledger	4	5	Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount		Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	See	Home Office Allocation	\$ 498,801		HCR Manor Care, Inc.	100.00%	\$ 498,801		1
2	V	Page								2
3	V	8								3
4	V									4
5	V									5
6	V	10a	Therapy Management	46,220		Heartland Management Services	100.00%	46,220		6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total			\$ 545,021				\$ 545,021	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

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Facility Name & ID Number ManorCare at Oak Lawn-Kostner # 0027557 Report Period Beginning: 06/01/02 Ending: 05/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ManorCare at Oak Lawn-Kostner # 0027557 Report Period Beginning: 06/01/02 Ending: 05/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization HCR Manor Care, Inc.
 Street Address 333 Noth Summit St.
 City / State / Zip Code Toledo, OH 43604-2617
 Phone Number (419) 252-5500
 Fax Number (419) 254-5495

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1 Dietary - Direct	Accumulated Cost	2,276,617,075	357 Nurs. Fac	\$	\$		0	1
2	1 Dietary - Pooled	Accumulated Cost	2,686,344,447	357 Nurs. Fac	920,912	536,824	8,222,195	2,819	2
3	5 Utilities - Direct	Accumulated Cost	2,276,617,075	357 Nurs. Fac	112,862		8,222,195	408	3
4	5 Utilities - Pooled	Accumulated Cost	2,686,344,447	357 Nurs. Fac	3,618,915		8,222,195	11,077	4
5	10 Nursing - Direct	Accumulated Cost	2,276,617,075	357 Nurs. Fac	11,131,912	7,408,777	8,222,195	40,204	5
6	10 Nursing - Pooled	Accumulated Cost	2,686,344,447	357 Nurs. Fac	2,842,925	1,812,855	8,222,195	8,701	6
7	17 General & Admin - Direct	Accumulated Cost	2,276,617,075	357 Nurs. Fac	19,326,083	15,188,841	8,222,195	69,798	7
8	17 General & Admin - Pooled	Accumulated Cost	2,686,344,447	357 Nurs. Fac	66,522,981	38,146,902	8,222,195	203,609	8
9	22 Employee Benefits - Direct	Accumulated Cost	2,276,617,075	357 Nurs. Fac	2,749,439		8,222,195	9,930	9
10	22 Employee Benefits - Pooled	Accumulated Cost	2,686,344,447	357 Nurs. Fac	25,498,075		8,222,195	78,042	10
11	30 Depreciation - Direct	Accumulated Cost	2,276,617,075	357 Nurs. Fac	148,355		8,222,195	536	11
12	30 Depreciation - Pooled	Accumulated Cost	2,686,344,447	357 Nurs. Fac	17,998,306		8,222,195	55,088	12
13									13
14	32 Interest				7,352,132			18,589	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 158,222,897	\$ 63,094,199		\$ 498,801	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Conv. Sub Debentures		X	Facility			\$ 461,443	\$ 461,443		4.0290	\$ 18,589	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8	Interest Income Other										(512)	8	
9	TOTAL Facility Related						\$ 461,443	\$ 461,443			\$ 18,077	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 461,443	\$ 461,443			\$ 18,077	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **ManorCare at Oak Lawn-Kostner**# **0027557** Report Period Beginning: **06/01/02** Ending: **05/31/03****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2002 report.		\$ 344,792	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 374,308	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 29,516	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 396,902	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$ 14,720	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 441,138	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1998 410,588	8	
	1999 419,671	9	
	2000 432,003	10	
	2001 393,539	11	
	2002 416,612	12	
Line 2: \$374,308 = \$196,770 for 1st half of 2002 + \$177,538 for 2nd half of 2001			
Line 4: \$396,902 = \$219,842 for 2nd half of 2002 + \$177,060 for Jan-May 2003			
Ernst & Young provided services to reduce our assessed valuations for 1999-2001. The \$14,720 reported on line 5 relates to reduction in assessed value for the 2001 taxes. The 2nd half of 2001 was paid correctly in Oct 2002.			
		FOR OHF USE ONLY	
	13 FROM R. E. TAX STATEMENT FOR 2002 \$		13
	14 PLUS APPEAL COST FROM LINE 5 \$		14
	15 LESS REFUND FROM LINE 6 \$		15
	16 AMOUNT TO USE FOR RATE CALCULATION \$		16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ManorCare at Oak Lawn-Kostner COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0027557

CONTACT PERSON REGARDING THIS REPORT Gary Geise

TELEPHONE (419)252-5731 FAX #: (419)254-5495

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>24-03-400-032-0000</u>	<u>See attached</u>	\$ <u>416,611.65</u>	\$ <u>416,611.65</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>416,611.65</u>	\$ <u>416,611.65</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

A. Square Feet:
 38,171

B. General Construction Type:
 Exterior
 Masonry
 Frame
 Steel
 Number of Stories
 2

C. Does the Operating Entity?
 ☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1977	\$ 257,674	1
2					2
3	TOTALS			\$ 257,674	3

Facility Name & ID Number ManorCare at Oak Lawn-Kostner

0027557

Report Period Beginning:

06/01/02

Ending:

05/31/03

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	157		1977	1977	\$ 2,247,698	\$ 62,436		\$ 62,436	\$	\$ 1,591,990	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
10	Current Year Depreciation					178,980		178,980		1,448,238	9
11			1981	1981	18,089						10
12			1986	1986	2,797						11
13			1988	1988	19,012						12
14			1989	1989	14,714						13
15			1990	1990	202,653						14
16			1991	1991	69,401						15
17			1992	1992	114,373						16
18			1993	1993	63,254						17
19			1994	1994	648,943						18
20			1995	1995	220,796						19
21			1996	1996	238,261						20
22			1997	1997	230,127						21
23			1998	1998	319,666						22
24			1999	1999	57,192						23
25			2000	2000	2,724						24
26			2000	2000	9,500						25
27			2000	2000	1,155						26
28			2000	2000	637						27
29			2000	2000	4,100						28
30			2000	2000	17,580						29
31			2000	2000	1,365						30
32			2000	2000	11,890						31
33			2000	2000	2,115						32
34			2000	2000	12,000						33
35			2000	2000	2,575						34
36			2000	2000	3,815						35
37			2000	2000	1,615						36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	A/C UNITS (4)	2001	\$ 2,501	\$		\$	\$	\$	37
38	CONCRETE	2001	17,820						38
39	WINDOW TREATMENTS	2001	333						39
40	CURTAINS/DRAPERIES	2001	15,426						40
41	BUILD INTERIOR WALL & CABINETS	2001	16,202						41
42	FLOORING - CARPET/VINYL	2001	10,615						42
43	ELECTRICAL WORK	2001	1,863						43
44	WALLCOVERING, BORDERS, CORNER GUARDS, PAINT	2001	60,735						44
45	FRONT DOORS	2001	1,705						45
46	STEEL GATES FOR DUMSTERS	2002	6,355						46
47	WINDOW TREATMENTS	2002	4,782						47
48	Renovation - General Construction	2002	28,263						48
49	Renovation - Wallcovering	2002	72,293						49
50	Renovation - HVAC & Electrical	2002	3,990						50
51	ROOFING ON WEST SECTION	2003	19,000						51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,799,930	\$ 241,416		\$ 241,416	\$	\$ 3,040,228	70

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,499,510	\$ 83,261	\$ 83,261	\$		\$ 1,320,568	71
72	Current Year Purchases	171,810						72
73	Fully Depreciated Assets							73
74				55,624	55,624			74
75	TOTALS	\$ 1,671,320	\$ 83,261	\$ 138,885	\$ 55,624		\$ 1,320,568	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RESIDENT	1996 CHRYSLER VAN	1996	\$ 36,664	\$	\$	\$		\$ 36,664	76
77										77
78										78
79										79
80	TOTALS			\$ 36,664	\$	\$	\$		\$ 36,664	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,765,588	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 324,677	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 380,301	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 55,624	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,397,460	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	SET-UP BUILDING	\$ 3,713,060	\$ 103,141	\$ 2,226,117	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 3,713,060	\$ 103,141	\$ 2,226,117	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☒ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 49,349 Description: 02 Concentrators, Wheelchairs, Gerichairs, Elct. Beds, Etc.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2004 \$ _____

13. /2005 \$ _____

14. /2006 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist	10a	5959	hrs	\$ 166,722	136	\$ 6,953	\$ 3,177	6,095	\$ 176,852	1
2	Licensed Speech and Language Development Therapist	10a	1985	hrs	48,380			138	1,985	48,518	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	4847	hrs	134,550	77	4,563	2,853	4,924	141,966	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39, 2		# of prescripts				455,219		455,219	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							
10				hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify): X-ray & Laboratory	43, 3					56,203			56,203	13
14	TOTAL				\$ 349,652	213	\$ 67,719	\$ 461,387	13,004	\$ 878,758	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (61,121)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 316,792)	1,473,269		3
4	Supply Inventory (priced at)	19,116		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	6,377		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,437,641	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	257,674		13
14	Buildings, at Historical Cost	4,799,930		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,707,984		16
17	Accumulated Depreciation (book methods)	(4,397,460)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Construction In Progress	85,275		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,453,403	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,891,044	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 103,867	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	387,500		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	396,902		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payables	79,852		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 968,121	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	16,906		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 16,906	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 985,027	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,906,017	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,891,044	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,619,241	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,619,241	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	3,163,980	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 3,163,980	17
	B. Transfers (Itemize):		
18	Change in interdivision	(3,877,204)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (3,877,204)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,906,017	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 8,250,351	1
2	Discounts and Allowances for all Levels	(1,548,809)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,701,542	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,225,715	6
7	Oxygen	45,379	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,271,094	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,713	12
13	Barber and Beauty Care	4,774	13
14	Non-Patient Meals	679	14
15	Telephone, Television and Radio	6,014	15
16	Rental of Facility Space		16
17	Sale of Drugs	452,309	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	45,734	19
20	Radiology and X-Ray	12,896	20
21	Other Medical Services		21
22	Laundry	15,332	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 539,451	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. income 1,253 + Purchase Discount 12	1,265	28
28a	Late charges	2,327	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,592	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,515,679	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	974,778	31
32	Health Care	3,595,353	32
33	General Administration	2,233,248	33
	B. Capital Expense		
34	Ownership	814,809	34
	C. Ancillary Expense		
35	Special Cost Centers	647,553	35
36	Provider Participation Fee	85,958	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,351,699	40
41	Income before Income Taxes (line 30 minus line 40)**	3,163,980	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 3,163,980	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **ManorCare at Oak Lawn-Kostner**# **0027557**Report Period Beginning: **06/01/02**Ending: **05/31/03**

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,762	1,901	\$ 63,185	\$ 33.24	1
2	Assistant Director of Nursing	5,050	5,448	138,498	25.42	2
3	Registered Nurses	17,943	19,360	447,313	23.11	3
4	Licensed Practical Nurses	38,788	41,850	744,814	17.80	4
5	Nurse Aides & Orderlies	97,100	104,764	929,757	8.87	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	12,809	13,808	376,913	27.30	7
8	Rehab/Therapy Aides	17,865	19,258	332,901	17.29	8
9	Activity Director	7,542	8,128	78,108	9.61	9
10	Activity Assistants					10
11	Social Service Workers	4,072	4,429	58,260	13.15	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,121	25,152	265,424	10.55	15
16	Dishwashers					16
17	Maintenance Workers	3,875	4,171	61,043	14.64	17
18	Housekeepers	18,130	19,564	163,132	8.34	18
19	Laundry	5,495	5,937	41,493	6.99	19
20	Administrator	2,080	2,080	112,933	54.29	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,856	16,792	250,921	14.94	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,096	4,425	46,726	10.56	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	274,584	297,067	\$ 4,111,421 *	\$ 13.84	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	20,500	9, 3	36
37	Medical Records Consultant		4,582	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,210	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 31,292		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes		F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount
Vicki Tomer	Administrator	0	\$ 112,933	Workers' Compensation Insurance	\$ 122,602	IDPH License Fee	\$ 4,499
				Unemployment Compensation Insurance	38,499	Advertising: Employee Recruitment	19,968
				FICA Taxes	312,607	Health Care Worker Background Check (Indicate # of checks performed <u>79</u>)	974
				Employee Health Insurance	324,163	Dues & Subscriptions	825
				Employee Meals		Association Dues	6,426
				Illinois Municipal Retirement Fund (IMRF)*		Advertising	15,188
				Employee Appreciation	4,321	Public Relations	4,643
				401K	23,445		
				Other Employee Benefits	4,824		
				Tuition Program	657	Less: Non-allowable Association Dues	(2,292)
				SMSP Match	2,400	Less: Public Relations Expense	(4,643)
				Employee Uniforms	2,684	Non-allowable advertising	(15,188)
				Home Office Allocation	87,972	Yellow page advertising	(
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 112,933	TOTAL (agree to Schedule V, line 22, col.8)	\$ 924,174	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 30,400
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Description	Amount
Management Fees			\$ 498,801			Out-of-State Travel	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 498,801			In-State Travel	1,463
C. Professional Services						Includes travel expense to the Home Office in Toledo, OH for regional meetings	
Vendor/Payee	Type		Amount			Seminar Expense	
Foote, Meyers, Mielke, Flowers & So	Legal Fees - Collections		\$ 32,496				
Purcell & Wardmole Chartered	Legal Fees - Collections		471				
Cooper Walinski & Cramer	Legal Fees - Collections		636				
Physicians Credit Bureau	Bad Debt Collection Fees		153				
The Weissman Group	HR / Union Consultant		1,453				
Legal & Collection fees were adjusted off on Schedule VI, Page 5, Line 22. Therefore, no legal invoices are attached.							
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 35,209	TOTAL	\$	Entertainment Expense	(
						(agree to Sch. V, line 24, col. 8)	
						TOTAL	\$ 1,463

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA \$6426
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes \$2292
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5-10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 52,288 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 85,958
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 679
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? No
Attach invoices and a summary of services for all architect and appraisal fees.